

Site code Participant code Infant
Number

 | | | | | | | | |

Name of Person Completing the Form: _____

Today's date: ____/____/____
 MM DD YYYY

5. Infant's birthdate? ____/____/____ ₇₇ Don't know
 M M D D Y Y Y Y

6. Gestational age at time of birth? _____ weeks _____ days

7. What was the basis of the gestational age at birth?

- ₁ Last menstrual period
- ₂ Ultrasound
- ₃ Assisted reproduction
- ₄ Other

8. Infant's sex? ₁ Male ₀ Female

9. Infant's birth weight (<12 hours after delivery)? _____ grams kilograms pounds ₇₇ Don't know

10. Infant's crown-to-heel length? _____ inches centimeters ₇₇ Don't know

11. Infant's head circumference (Occipito-frontal after 24h following birth)? _____ centimeters ₇₇ Don't know

12. Infant's APGAR score?

- 1 minutes after birth _____, ₇₇ Don't know
- 5 minutes after birth _____, ₇₇ Don't know
- 10 minutes after birth _____, ₇₇ Don't know

13. Infant's maximum temperature at birth: _____°C or _____°F
₁ Oral ₂ Tympanic ₃ Rectal ₄ Axillary

14. How was the infant delivered? (tick one box)

- ₁ Vaginal spontaneous
- ₂ Vaginal assisted (eg. forceps, vaccuum)
- ₃ Caesarian section
- ₄ Assisted Breach
- ₇₇ Don't know

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15. What was the fetal presentation of the infant at delivery? (tick one box)

- ₁ Cephalic
₂ Breech
₃ Other

16. Where was the infant delivered? (tick one box)

- ₁ Home
₂ Health facility
₇₇ Don't know

17. Were there intra-partum complications? ₁ Yes ₀ No ₇₇ Don't know

18. Were there post-partum complications? ₁ Yes ₀ No ₇₇ Don't know

19. Please indicate the infant has had of any of the following conditions by marking "yes", "no" or "I don't know". If you mark yes in any of the conditions please fill out the fourth column to the right of each individual condition.

	Yes	No	I don't know	If yes.....,
Seizures				<input type="checkbox"/> ₁ General <input type="checkbox"/> ₂ Focal
Paralysis				<input type="checkbox"/> ₁ General <input type="checkbox"/> ₂ Ascending
Increased stiffness in limbs				Describe: _____
Floppiness (hypotonia)				Describe: _____
Joint contractures				Describe: _____
Other neurological signs				Describe: _____
Oedema				Describe: _____
Apnea				Describe: _____
Rash				Type of rash: _____ Date of rash onset (mm/dd/yyyy): _____
Other abnormal skin condition				Type: _____ Date of onset (mm/dd/yyyy): _____

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20. Please indicate if any of the following birth abnormalities were present ≤ 24 post-delivery by marking “yes”, “no” or “I don’t know” for each one.

	Yes	No	I don't know
Facial Dysmorphia			
Cleft lip/palate			
Eye abnormalities			
Ear abnormalities			
Excess head skin			
Small skull (Craniosynostosis)			
Down syndrome features			
Enlarged back of the head			
Congenital heart defects			
Lump under the skin (Haemangiomas)			
Umbilical hernia			
Abdominal wall defect			

21. Please indicate if any of the following birth abnormalities were present ≤ 24 post-delivery by marking “yes”, “no” or “I don’t know” for each one. If you mark yes in any of the conditions please fill out the fourth column to the right of each individual condition.

	Yes	No	I don't know	If yes,
Hand abnormalities				<input type="checkbox"/> ₁ Missing fingers <input type="checkbox"/> ₂ Curving of the little finger towards ring finger <input type="checkbox"/> ₃ Other
Foot abnormalities				<input type="checkbox"/> ₁ Wide spaced toes <input type="checkbox"/> ₂ Clubfoot <input type="checkbox"/> ₃ Other
Upper limb abnormalities				Describe: _____
Lower limb abnormalities				Describe: _____

22. Was imaging performed on the infant within 24 hours after birth? ₁ Yes ₀ No ₇₇ Don't know

If yes, what type? (tick box)

₁ Cranial ultrasound scan
 Result: ₁ Normal ₂ Abnormal

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- CT scan
Result: Normal Abnormal
- MRI
Result: Normal Abnormal
- Other
Result: Normal Abnormal

PART III: Microbiology testing

23. Was a blood specimen taken? Yes No

23a. *If no, why?*

- The last two study related blood draws came out negative for Zika virus infection
- Other, specify _____

23b. *If yes,*

23.b.1. Date of specimen collection (mm/dd/yyyy): _____

23.b.2. Time of specimen collection (hh:mm): _____

23.b.3. Date specimen was sent to laboratory (mm/dd/yyyy): _____

23.b.4. Type of test:

- RT-PCR
- IgM
- RT-PCR & IgM
- Other

24. Was a urine sample taken? Yes No

24a. *If no, why?*

- The last two study related urine samples came out negative for Zika virus infection
- Other, specify _____

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24.b. *If yes,*

24.b.1. Date of specimen collection (mm/dd/yyyy): _____

24.b.2. Time of specimen collection (hh:mm): _____

24.b.3. Date specimen was sent to laboratory (mm/dd/yyyy): _____

24.b.4. Type of test:

₀ RT-PCR

₁ IgM

₂ RT-PCR & IgM

₃ Other

25. Was a cerebrospinal fluid (CSF) sample taken from the infant after birth? ₁ Yes ₀ No ₇₇ *Don't know*

If yes, Date (mm/dd/yyyy): _____

If yes, Fluid appearance: ₁ Clear and colourless ₂ Cloudy ₃ Blood stained ₄ Unknown

26. Was a pediatrician identified for the follow-up of the infant? ₁ Yes ₀ No

If no, why not? _____

NOTE: A PEDIATRICIAN MUST BE IDENTIFIED BY THE STUDY STAFF PRIOR TO THE INFANTS DEPARTURE FROM THE DELIVERY HOSPITAL/CLINIC